Comparison of Medical Plans

The Hanford Employee Welfare Trust (HEWT) offers three medical plans to eligible employees and their eligible enrolled dependents.

To compare specific benefits between plans, identify the benefit you wish to compare from the tables below.

The following is intended to give general information about these plans but is not a comprehensive plan description. Should any question arise about the nature and extent of benefits under these plans, or should there be any errors in this comparison, the formal plan documents/contracts and not the information in this comparison will govern.

*****The comparison located in the tables below are effective January 1, 2004*****

ANNUAL PLAN DEDUCTIBLE			
BENEFITS	**GROUP HEALTH HMO**	**GROUP HEALTH *"Options"* (Point of Service)**	**UnitedHealthCare PPO**
In Network	None	None	$200 individual / $400 family
Out of Network	N/A	$200 individual / $400 family	$300 individual / $600 family

PRE-EXISTING CONDITION LIMITATION			
BENEFITS	**GROUP HEALTH HMO**	**GROUP HEALTH *"Options"* (Point of Service)**	**UnitedHealthCare PPO**
In Network	None	None	None
Out of Network	None	None	None

ANNUAL OUT-OF-POCKET LIMIT			
BENEFITS	**GROUP HEALTH HMO**	**GROUP HEALTH *"Options"* (Point of Service)**	**UnitedHealthCare PPO**
In	$1,000 individual / $2,000 Family	$650 individual / $1,300 Family	$1,000 individual / $2,000 family

Network			
Out of Network	N/A	$750 individual / $1,500 Family	$3,000 individual / $6,000 family

MAXIMUM BENEFIT (PER PERSON ANNUAL/LIFETIME)			
BENEFITS	**GROUP HEALTH HMO**	**GROUP HEALTH *"Options"* (Point of Service)**	**UnitedHealthCare PPO**
In Network	No max limit	No max limit	$1,500,000 individual / $1,500,000 family
Out of Network	N/A	No max limit	$1,500,000 individual / $1,500,000 family

CO-INSURANCE			
BENEFITS	**GROUP HEALTH HMO**	**GROUP HEALTH *"Options"* (Point of Service)**	**UnitedHealthCare PPO**
In Network	None	None	85% / 15%
Out of Network	N/A	80% / 20%	60% / 40%

INPATIENT HOSPITAL SERVICES			
BENEFITS	**GROUP HEALTH HMO**	**GROUP HEALTH *"Options"* (Point of Service)**	**UnitedHealthCare PPO**
In Network	Covered in full	Covered in full	85% / 15%
Out of Network	N/A	80% / 20%	60% / 40%

OUTPATIENT HOSPITAL SERVICES			
BENEFITS	**GROUP HEALTH HMO**	**GROUP HEALTH *"Options"* (Point of Service)**	**UnitedHealthCare PPO**
In Network	Covered in full	Covered in full	85% / 15%
Out of Network	N/A	80% / 20%	60% / 40%

EMERGENCY CARE			
BENEFITS	**GROUP HEALTH HMO**	**GROUP HEALTH *"Options"* (Point of Service)**	**UnitedHealthCare PPO**
	$10 Co-Pay: In-Area $50 Co-Pay: Out-of-Area	$15 Co-Pay: In-Area $65 Co-Pay Out-of-Area	$50 per visit plus 15%, after deductible

AMBULANCE			
BENEFITS	**GROUP HEALTH HMO**	**GROUP HEALTH *"Options"* (Point of Service)**	**UnitedHealthCare PPO**
In Network	Covered in full	80% / 20%	85% / 15%, after deductible
Out of Network	N/A	80% / 20% (not subject to deductible)	85% / 15%, after deductible

PHYSICIAN'S OFFICE SERVICES			
OFFICE VISIT / URGENT CARE			
BENEFITS	**GROUP HEALTH HMO**	**GROUP HEALTH *"Options"* (Point of Service)**	**UnitedHealthCare PPO**
In Network	$10 Co-pay	$15 Co-pay	85% / 15%
Out of Network	N/A	80% / 20%	60% / 40%
LAB AND X-RAY SERVICES			
In Network	Covered in full	Covered in full	85% / 15%
Out of Network	N/A	80% / 20%	60% / 40%

MATERNITY SERVICES			
BENEFITS	**GROUP HEALTH HMO**	**GROUP HEALTH *"Options"* (Point of Service)**	**UnitedHealthCare PPO**
In Network	$60 Co-pay for all services	**Inpatient** - Covered in full **Outpatient** - $15 Co-Pay	85% / 15%
Out of Network	N/A	80% / 20%	60% / 40%

PREVENTIVE CARE SERVICES			
BENEFITS	**GROUP HEALTH HMO**	**GROUP HEALTH *"Options"* (Point of Service)**	**UnitedHealthCare PPO**
In Network	$10 Co-pay	Covered in full	Some at 100%
Out of Network	N/A	Covered up to $150	Paid at 40%

REHABILITATION SERVICES			
BENEFITS	**GROUP HEALTH HMO**	**GROUP HEALTH *"Options"* (Point of Service)**	**UnitedHealthCare PPO**
In Network	**Inpatient** - Covered in full, 60 days per condition per year **Outpatient** - $10 Co-pay, 60 visits per condition per year	**Inpatient** - Covered in full, 60 days per condition per year **Outpatient** - $15 Co-pay, 60 visits per condition per year	**Inpatient** - 85% / 15%, 60 days per condition per year **Outpatient** - 85% / 15%, up to 30 visits per condition per year (20 visits for cardiac and pulmonary)
Out of Network	N/A	**Inpatient** - 80% / 20%, 60 days per condition per year **Outpatient** - 80% / 20%, 60 visits per condition per year	**Inpatient** - 60% / 40%, 60 days per condition per year **Outpatient** - 60% / 40%, Up to 30 visits per condition per year (20 visits for cardiac and pulmonary)

DURABLE MEDICAL EQUIPMENT AND SUPPLIES (DETERMINED MEDICALLY NECESSARY. EXAMPLES INCLUDE: HOSPITAL BEDS, WHEELCHAIRS, etc.)			
BENEFITS	**GROUP HEALTH HMO**	**GROUP HEALTH *"Options"* (Point of Service)**	**UnitedHealthCare PPO**
In Network	Covered in full	Covered in full	85% / 15% plus deductible
Out of Network	N/A	Covered in full (not subject to deductible)	60% / 40% plus deductible

PRESCRIPTION DRUGS			
BENEFITS	**GROUP HEALTH HMO**	**GROUP HEALTH *"Options"* (Point of Service)**	**UnitedHealthCare PPO**
In Network	$10 Co-pay for a 30-day supply Up to a 90-day supply of maintenance medications for 1 Co-pay. Allergy serum - covered in full (subject to formulary)	$10 Generic / $15 Brand for a 30-day supply Up to a 90-day supply of maintenance medications for 1 Co-pay Allergy serum - covered in full (subject to formulary)	**Retail** (up to a 30-day supply): $5 generic / $15 brand name plus $50 per person annual deductible. **Mail Order** (up to a 90-day supply): $9 generic / $15 brand (no deductible)

Out of Network	N/A	80% / 20% (not subject to deductible)	80% up to 90-day supply

MENTAL HEALTH SERVICES

INPATIENT HOSPITAL

BENEFITS	GROUP HEALTH HMO	GROUP HEALTH *"Options"* (Point of Service)	UnitedHealthCare PPO
In Network	80% / 20% up to 12 days	80% / 20%, up to 12 days	100% paid, 60 days per year
Out of Network	N/A	80% / 20%, up to 12 days	Mental Health: 40% up to 20 days per year Substance Abuse: 50% up to $5,000 per year

OUTPATIENT

BENEFITS	GROUP HEALTH HMO	GROUP HEALTH *"Options"* (Point of Service)	UnitedHealthCare PPO
In Network	$20 individual / $10 group, 20 visit limit	$20 individual / $10 group, 20 visit limit	$15 individual / $5 group, 60 visit limit
Out of Network	N/A	50% Co-insurance, 20 visit limit	50% Co-insurance, 25 visits limit

CHEMICAL DEPENDENCY

BENEFITS	GROUP HEALTH HMO	GROUP HEALTH *"Options"* (Point of Service)	UnitedHealthCare PPO
In Network	$10 Co-Pay	$15 Co-pay	**Inpatient:** 100 / 0% Co-insurance 60 days per year **Outpatient:** $15 individual / $5 group maximum of 60 visits per year
Out of Network	N/A	80% / 20%	**Inpatient:** 50% Co-insurance 20 days per year, maximum of $5,000 / year **Outpatient:** 50% for Substance Abuse up to 25 visits per year.

CHIROPRACTIC CARE SERVICES

BENEFITS	GROUP HEALTH HMO	GROUP HEALTH *"Options"* (Point of Service)	UnitedHealthCare PPO
In Network	$10 co-pay per visit / maximum 10 visits per year	$15 co-pay per visit - maximum 10 visits per year	85% / 15% - 20 visits limit per year, In and Out of Network combined
Out of Network	N/A	80% / 20% - maximum 10 visits per year	60% / 40% - 20 visits limit per year, In and Out of Network combined

VISION CARE SERVICES

EXAMINATIONS (LIMIT ONE VISIT PER CALENDAR YEAR)

BENEFITS	GROUP HEALTH HMO	GROUP HEALTH *"Options"* (Point of Service)	UnitedHealthCare PPO
In Network	$10 Co-pay - Once every 12 months	$15 Co-pay - Once every 12 months	Annual Exam: $10 Co-pay
Out of Network	N/A	Covered up to $30 once every 12 months (not subject to deductible)	Annual Exam: 85% maximum reimbursement in a calendar year ($150 for exam and hardware combined)

OPTICAL HARDWARE

BENEFITS	GROUP HEALTH HMO	GROUP HEALTH *"Options"* (Point of Service)	UnitedHealthCare PPO
In Network	Covered up to $150 Once every 24 months per member	Covered up to $150 Once every 24 months per member	Lenses every 12 months: $10 Co-pay Frames every 24 months
Out of Network	N/A	Covered up to $150 Once every 24 months per member	Frames and lenses every other year up to $150 total (including exam)

EMPLOYEE COST SHARE AND CONTACT INFORMATION

EMPLOYEE COST SHARE

BENEFITS	GROUP HEALTH HMO	GROUP HEALTH *"Options"* (Point of Service)	UnitedHealthCare PPO
Employee only	$22.37	$25.74	$49.65
Employee + one	$39.61	$48.07	$97.66
Employee + more than one	$68.86	$79.48	$158.72

CONTACT INFORMATION AND MORE INFORMATION ABOUT THE PLANS

	Tri-Cities: 1-800-458-5450 / 1-509-783-3484 **Yakima:** 1-800-274-2140 / 1-509-574-3143 **Web**: http://www.ghc.org	**Tri-Cities:** 1-800-458-5450 / 1-509-783-3484 **Yakima:** 1-800-274-2140 / 1-509-574-3143 **Web**: http://www.ghc.org	**For Medical Benefits:** Call UHC Customer Service (1-866-249-7606) **For Vision:** Call Spectera Vision (1-800-638-3120) **For Mental Health/Substance Abuse:** Call United Behavioral Care (1-800-888-2998) **For Prescription Drugs:** Call

			Express Scripts (1-800-796-7518) **UnitedHealthCare Web:** http://www.myuhc.com **Express Scripts Web:** http://www.express-scripts.com

EMPLOYEE/COMPANY/TOTAL COST SHARE FOR MEDICAL PREMIUMS			
EMPLOYEE COST SHARE			
BENEFITS	**GROUP HEALTH** **HMO**	**GROUP HEALTH** ***"Options"*** **(Point of Service)**	**UnitedHealthCare** **PPO**
Employee only	$22.37	$25.74	$49.65
Employee + one	$39.61	$48.07	$97.66
Employee + more than one	$68.86	$79.48	$158.72
COMPANY COST SHARE			
BENEFITS	**GROUP HEALTH** **HMO**	**GROUP HEALTH** ***"Options"*** **(Point of Service)**	**UnitedHealthCare** **PPO**
Employee only	$310.60	$321.16	$452.43
Employee + one	$568.15	$588.64	$856.29
Employee + more than one	$948.81	$984.91	$1,397.72
TOTAL PREMIUM COST			
BENEFITS	**GROUP HEALTH** **HMO**	**GROUP HEALTH** ***"Options"*** **(Point of Service)**	**UnitedHealthCare** **PPO**
Employee only	$332.97	$346.90	$502.08
Employee + one	$607.76	$636.71	$953.95
Employee + more than one	$1,017.67	$1,064.39	$1,556.44